

DATE: \_\_\_\_\_ NEEDS BY DATE: \_\_\_\_\_ SHIP TO:  PATIENT  OFFICE - FIRST DOSE  OFFICE - ALL DOSES  OTHER \_\_\_\_\_

PATIENT INFORMATION			
Patient Name			
Address			
City	State	Zip	
Main Phone	Alternative Phone	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Social Security #		Date of Birth	

PRESCRIBER INFORMATION			
Prescriber Name			
Prescriber Type <input type="checkbox"/> Physician (MD or DO) <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician's Assistant			
Supervising Physician (If prescriber is a NP or PA)			
DEA #	NPI #	Tax ID #	
Address			
City	State	Zip	
Phone	Fax		
Contact Person			

### INSURANCE: PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
<input type="checkbox"/> Ilumya™	100 mg Pre-filled syringe	<input type="checkbox"/> <b>INITIAL:</b> Inject 100 mg SQ at week 0 and week 4 <input type="checkbox"/> <b>MAINTENANCE:</b> Inject 100 mg SQ every 12 weeks thereafter	1 1	1 _____
<input type="checkbox"/> Otezla®	<input type="checkbox"/> Starter Pack <input type="checkbox"/> 30mg Tablets	<input type="checkbox"/> <b>Titrate:</b> Take 1 tablet on day 1 then twice daily as directed <b>OR date provided</b> _____ <input type="checkbox"/> <b>Maintenance:</b> Take 1 tablet by mouth <b>ONCE</b> daily <input type="checkbox"/> <b>Maintenance:</b> Take 1 tablet by mouth <b>TWICE</b> daily.	1 Starter Pack 30 60	_____
<input type="checkbox"/> Otezla® <i>Bridge Rx</i>	30mg Tablets	<input type="checkbox"/> Bridge Rx: Take 1 tablet by mouth <b>TWICE</b> daily; dispensed by OSP <b>(Recommended daily dose) ***Starter Pack Provided Date:</b> _____ <input type="checkbox"/> Bridge Rx: Take 1 tablet by mouth <b>ONCE</b> daily; dispensed by OSP <b>(For Patients with severe renal impairment)</b>	28	6 12
<input type="checkbox"/> Siliq™	210mg Pre-filled Syringe	<input type="checkbox"/> <b>Initial:</b> Inject 210 mg SQ on weeks 0, 1, and 2 <input type="checkbox"/> <b>Maintenance:</b> Inject 210 mg SQ every 2 weeks starting at week 4	3 4 Week Supply	0 _____
<input type="checkbox"/> Skyrizi™	75 mg Pre-filled Syringe	<input type="checkbox"/> <b>Initial:</b> Inject 150 mg (2 syringes) SQ at weeks 0 & 4 <input type="checkbox"/> <b>Maintenance:</b> Inject 150 mg ( 2 syringes) SQ every 12 weeks	1 box (2 syringes) 1 box (2 syringes)	1 _____
<input type="checkbox"/> Stelara®	<input type="checkbox"/> 45mg Pre-filled Syringe <input type="checkbox"/> 90mg Pre-filled Syringe <b>Weight Required:</b> _____	<input type="checkbox"/> Inject 45mg on day 0, then week 4, then every 12 weeks ( <b>Patients ≤ 220lbs</b> ) <input type="checkbox"/> Inject 90mg on day 0, then week 4, then every 12 weeks ( <b>Patients &gt; 220lbs</b> )	4 Week Supply	_____
<input type="checkbox"/> Tremfya™	<input type="checkbox"/> One- Press Injector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> <b>Initial:</b> Inject 100 mg SQ at week 0 and then at week 4 <input type="checkbox"/> <b>Maintenance:</b> Inject 100 mg SQ every 8 weeks	1 1	1 _____
<input type="checkbox"/> Taltz®	<input type="checkbox"/> Auto Injector <input type="checkbox"/> Prefilled Syringe	<input type="checkbox"/> <b>Starting:</b> Inject 160 mg SQ on day 1, then begin first induction dose 2 weeks later (week 2) <input type="checkbox"/> <b>Induction:</b> Inject 80 mg SQ every 2 weeks (weeks 4-10) <input type="checkbox"/> <b>Final Induction Dose:</b> Inject 80 mg SQ on week 12 <input type="checkbox"/> <b>Maintenance:</b> Inject 80 mg SQ every 4 weeks (thereafter)	3 2 1 1	0 1 0 _____
<input type="checkbox"/> Taltz® <small>Psoriatic Arthritis Only</small>	<input type="checkbox"/> Auto Injector <input type="checkbox"/> Pre-filled Syringe	<input type="checkbox"/> <b>Initial:</b> Inject 160 mg SQ on week 0 <input type="checkbox"/> <b>Maintenance:</b> Inject 80 mg SQ every 4 weeks	2 1	_____

### CLINICAL INFORMATION

Diagnosis:  L40.0 Moderate to Severe Plaque Psoriasis  L40.50 Psoriatic Arthritis  L73.2 Hidradenitis Suppurativa - Hurley Stage: \_\_\_\_\_  
 Other: \_\_\_\_\_ DX Code: \_\_\_\_\_  L20.9 Atopic Dermatitis unspecified

Location: % BSA: \_\_\_\_\_  Hands  Feet  Scalp  Groin  Nails  Other: \_\_\_\_\_ Patient Allergies: \_\_\_\_\_

Prior Failed Meds:  Cimzia  Cosentyx  Enbrel  Humira  Orencia  Remicade  Simponi  Soriatane  Stelara  Taltz

**Methotrexate** Length of Treatment: \_\_\_\_\_ Reason for Discontinuing: \_\_\_\_\_  
**PUVA/UVB** Length of Treatment: \_\_\_\_\_ Reason for Discontinuing: \_\_\_\_\_  
**Topicals** Length of Treatment: \_\_\_\_\_ Reason for Discontinuing: \_\_\_\_\_  
 Contraindicated Medication: \_\_\_\_\_ Reason: \_\_\_\_\_  
 Inadequate Response (List Specific Names): \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Hepatitis Test Result: \_\_\_\_\_ Hep B ruled out/treated:  Yes  No Date: \_\_\_\_\_  
 TB/PPD Test given?  Yes  No Test Date: \_\_\_\_\_ Test Results: \_\_\_\_\_ ISGA score: \_\_\_\_\_ EASI score: \_\_\_\_\_ POEM score: \_\_\_\_\_ SCORAD: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Dispense As Written (no stamps)

Date

Substitution Permitted (no stamps)

Date

1. In order for a brand name product to be dispensed, the prescriber must write "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language.  
 2. By signing this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copy and financial assistance on behalf of your patients when available.  
 3. The pharmacy can only accept faxed prescriptions directly from a prescriber's office.  
 4. Prescribers must comply with any of their state-specific prescription requirements.